Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS BACK INSTITUTE
PO BOX 262409
PLANO TX 75026-2409

Respondent Name
TPCIGA FOR RELIANCE NATIONAL INDEMNITY

Carrier's Austin Representative Box
Box Number 50

MFDR Tracking Number
M4-10-3966-01

MFDR Date Received
MAY 10, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The documentation we submitted was supported by the operative report. In order to perform an anterior lumbar fusion, a part of the disk is removed. The operative report clearly indicates that the disk was removed 'all the way to the posterior longitudinal ligament'. Using CPT code 63090 best describes the procedure performed. The '62' modifier was utilized for the co-surgeon."

Amount in Dispute: $3,037.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2010	CPT Code 63090-62	$3,037.00	$2,268.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.

   The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 45-Charges exceed fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)
- 111-001-Coventry contract status indicator 01-Contracted provider.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 863-Procedure/Service Code/Diagnosis is Code/Items billed – Not documented in report.
- 900-Based on further review, no additional allowance is warranted.
- B12-Service not documented in patients medical records.
- 080-001-Review of this bill has resulted in an adjusted reimbursement for the entire bill of $0.00.
- 39-Services denied at the time authorization/pre-certification was requested.
- 910-073-Services denied at the time authorization/pre-certification was requested.
- W1-Workers Compensation state fee schedule adjustment.

Issues

1. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
2. Does a preauthorization issue exist in this dispute?
3. Does the documentation support billed service?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
   (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

   (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

   On September 28, 2010, the Division requested a copy of the written notification to the health care provider pursuant to 28 Texas Administrative Code §133.4. No documentation was provided to sufficiently support that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

   28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

   The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 63090-62 based upon reason code "39".

   28 Texas Administrative Code §134.600 (c)(1)(B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   28 Texas Administrative Code §134.600(p)(1) states "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

   A review of the Utilization Management Referral report and January 15, 2010 preauthorization report support the requestor's position that CPT code 63090-62 was preauthorized. Therefore, the respondent's denial based upon reason code "39" is not supported.

3. CPT code 63090-62 is defined as “Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment.”

   The operative report indicates that “A total discectomy to the posterior longitudinal ligament curetting off the cartilage of the subchondral bone was performed.”

   The Division finds that the documentation supports billed service. Reimbursement is recommended.

4. 28 Texas Administrative Code §134.202(b) states “For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section.”

   The requestor appended modifier 62 to CPT code 63090. Modifier 62 is defined as “When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added.”

   Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.”

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 68.19.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75093, which is located in Collin County. The Medicare conversion factor for Collin County is 36.0791.

   The Medicare participating amount for code 23120 in Collin County is $1,920.36.

   Using the above formula, the MAR is $3,629.51. Because the 62 modifier was used reimbursement is 62.5% of the MAR; therefore, the MAR for a co-surgeon is $2,268.44. The respondent paid $0.00. The requestor is due $2,268.44.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,268.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,268.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		2/14/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.